STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 09/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 066	482.13(e)(3)(ii) PHYSICIAN ORDER FOR MEDICAL RESTRAINT The use of a restraint must be in accordance with the order of a physician or other licensed independent practitioner permitted by the State and hospital to order a restraint. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure a client record contained a restraint order for one client (client #1) who had been restrained and failed to notify the treating physician as soon as possible after the restraint. Findings include: Review of medical records and hospital documents on 9-12-06 and 9-13-06 revealed patient #1, a 12 year-old male who was admitted to Broughton Hospital on 8-1-06 with the diagnoses of Conduct Disorder, Adjustment Disorder, Mixed, with Disturbance of Conduct and Emotions, Family Conflict, Victim of Childhood Abuse. Patient #1 was discharged 8-15-06. Interview of patient advocate on 9-12-06 at 3:30pm revealed two CNAs (CNA #1 and #2) restrained patient #1 on 8-14-06 and failed to report the incident to the nurse. Interview revealed the advocate notified DSS, patient #1's mother (who could not be reached), management, and the HCPR (Health Care Personnel Registry). The patient advocate referred the investigation to Broughton Police who interrogated the CNAs. On 9-12-06 at 4:30pm an interview was	A 066		12/1/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 09/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 066	Continued From page 1	A 066		

conducted with the social worker. The social worker stated patient #1 ran up to her in the hall on 8-14-06 and showed her a red mark on his face. The social worker stated CNA #1 and CNA #2 were confronted and denied participating in a restraint process.

On 9-18-06 interview of CNA #1 per telephone revealed he had restrained patient #1 using a proper hold and he had denied the incident until interrogated by police on 8-21-06 at 8:00pm. CNA #1 described the method used in holding patient #1 to the bed. CNA #1 stated, "The patient was cursing and jumping around threatening the school teacher. He refused to go into his room, cursing. Two of us said,'If you don't, you'll have to go to Time Out.' Patient #1 yelled, 'You can't make me.' We approached, he jumped and ran and dove onto his bed. We were to assist him to Time Out and he started to spit and struggle. We put him in a hold, he was kicking. Dodging his kick, I held his face to stop the spit. It was about 5 seconds."

On 9-25-06 review of police report dated 8-21-06 revealed a statement by CNA #1 that included, "...patient #1 took off running back into patient #1's bedroom jumping onto patient #1's bed. As we approached to lay hands on him, he started kicking and screaming that he was going to spit on us. I (CNA #1) put my hand on his facial area to keep him from spitting on us."

Per 9-26-06 review of police report dated 8-22-06 revealed a statement by CNA #2, "I observed CNA #1 on the right side of patient #1's bed, with his knee on the bed, beside of patient #1. CNA#1 also had one hand on patient #1's leg and his forearm across

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 09/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 066	Continued From page 2	A 066		

patient #1's head trying to hold patient #1 down. I then approached patient #1 on the left side of his bed attempting to calm him down. He stated that he would calm down and stay in his room. CNA #1 then let him go and we walked out."

Further review of police report on 9-26-06 revealed, "After interviewing all parties involved and reviewing all the evidence produced, it is this Officer's opinion that there is not enough substantial evidence to support criminal charges. All reports and statements will be turned over to the Administration to be used in their investigation." This report was dated 8-22-06 and signed by Officer #595.

On 9-18-06 interview of CNA #2 per telephone revealed he had assisted to restrain patient #1 using a proper hold and he denied the incident until interrogated by police 8-22-06 at 6:30pm. CNA #2 stated the action had been as described above and he had held the feet of patient #1 during the hold.

On 9-12-06 the hospital policy entitled "Emergency Restrictive Interventions" was reviewed Page 2 of the policy stated "Emergency Restrictive Interventions: (Note: Any use must be ordered by a physician and reported on the incident report form.)"

Further review of the policy revealed attachment 1, "Procedures for Restrictive Interventions: The attachment stated "In the absence of a RN or psychiatrist, a CNA or another NCI-certified staff member initiates the emergency intervention then notifies the RN immediately. In cases where the RN is absent, and ITO, seclusion, or psychiatric

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344002	A. BUILDING _____ B. WING _____	C 09/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROUGHTON HOSP	1000 S STERLING ST MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 066	Continued From page 3 restraint is implemented, the patient may not be released until the assessment occurs by either the RN or psychiatrist." On 9-12-06 review of patient #1's medical record revealed no evidence of a physician's order for a restraint. On 9-12-06 review of the incident report for patient #1, dated 8-14-06, revealed the Restrictive Interventions section was left blank (no documentation of psychiatrist who ordered intervention, no documentation of type of intervention, etc.).	A 066		